Quarterly Meeting of the Prevention and Wellness Advisory Board

October 2, 2014, 1:00 p.m. – 2:30 p.m.

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Massachusetts Department of Public Health
Public Health Council Conference Room
240 Washington Street, 2nd Floor
Boston, MA 02108

Meeting Notes:

Introduction

1. Commissioner Cheryl Bartlett recommended that the Prevention and Wellness Advisory Board Members present review the minutes of the last meeting while waiting for a quorum to be present.
2. Quorum confirmed
3. Minutes of the June meeting were approved
4. Commissioner Bartlett announced the resignation of Lisa Renee Holderby-Fox, Executive Director MACHW and thanked Lisa for her service.
5. Overview of agenda

Commissioner Bartlett's comments:

> e-Referral is part of the Centers for Medicaid and Medicare SIM Grant. The intention of the e-referral model is to introduce a method for electronic two-way communication to enhance collaboration between community and clinical services. This technological tool compliments the development of PWTF Partnerships focused on better health outcomes and health care cost containment. The Prevention and Wellness Trust Fund is charged with working with and assisting the Partnerships as they develop infrastructure, and a framework and implementation strategy for their intervention programs. Internal infrastructure of the Coaching Team, e-Referral Team and Evaluation Team for supporting the interventions may serve as a nationwide model for development.

Carlene Pavlos, Director of Bureau of Community Health and Prevention introduced the TA Coaches with a summary of their role with the Prevention and Wellness Trust Fund (PWTF). Coordinating Partners (Grantees) are assisted with development of framework and implementation through coaching by TAs, Laura Coe, Pattie Daly, and Lissette Blondet.

Laura Coe, Partnership TA/QI, introduced herself as new to the PWTF Team and summarized her background with DPH. She worked with the CDC Quality Improvement Program on Stroke Prevention using a collaborative approach to QI and hopes to replicate some of the successful strategies used in that program. Her presentation includes background slides illustrating the role of the TA and their responsibility to improve healthcare, contain costs, and integrate Community and Clinical work-flow and communications that will allow illustrative reporting for evaluation of ROI.

Key components:

Priority Interventions based on cost savings. Short-term cost savings can be assessed not just on referrals but on coming together as a group. Collaborative models accelerate the pace of change and improvement. Data Collection and Analysis components will inform the work and direction of the Trust.

Capacity/Implementation/ Sustainability. 9 Partnerships are funded and organized in two Cohort groups set on different timelines. Cohort 1 was given a 6-month Capacity phase and Cohort 2 was given a 10-month Capacity phase. We will be looking at the impact of the additional months on the successful development of intervention programs. Some applicants had more experience working together – others who were new to a more collaborative framework required more work on relationship building. Cohort 2 had more time to plan and pilot different approaches.

Selection of Grantees. Distribution of Partnerships across the State, including rural and urban areas allow about 15% of the State population to be reached. Priority Conditions vs. Optional Conditions – Interventions focused on priority conditions are expected to show a positive ROI within 3-5 years, so the applicants were required to choose 2 of the 4 priority conditions.

Perspective – 3 years is a short time to improve a health condition – the p riority interventions can show improvement in a shorter period of time therefore, preventable, evidence-based interventions were selected. Economic factors were taken into consideration – expenditure on specific conditions was used to rank or order the health conditions, then consensus was reached on which trend would most clearly illustrate the impact of interventions. Reversing trends on a shorter term to show ROI was primary – a lot of research was used in selecting the interventions. Partnership selection of intervention allows focus on training, collaboration, supporting infrastructure and, ideally, continuation of intervention efforts beyond the recently developed programs that will soon be transitioning to implementation.

Question: Representative Jeffrey Sanchez asked whether or not and, if so, how do these programs work with or intersect with other existing initiatives. Are they a duplication of services? An example of an existing program would be Pediatric Asthma.

Response: Carlene Pavlos explained that the PWTF Team is working with the Grantees to develop a model, which includes being in sync with other initiatives of the DPH. There is a conscious effort to create synergy with existing programmatic efforts – integrating with technical assistance provided to grantees. Some of the work focuses on behavioral (Mass In Motion) and environmental factors. Work on some of the conditions is vital to an understanding of the secondary and tertiary layers of impact to help focus and enhance the ability to create other programs that piggy back on existing programs. There is and will continue to be a dialogue between DPH and HSS.

Response: Commissioner Cheryl Bartlett – being able to charge through CMS for Healthcare Workers is an important consideration for the future.

Key components (Continued from Laura Coe):

Selection of Clinical and Community Interventions were based partly on the analysis to create each Tier. The Tier 1 focus is on evidence based interventions, yet correlations between a Tier 1 and Tier 2 and 3 interventions may exist, so they are included in the programs.The Advisory Board encouraged innovation not simply existing evidence. Analysis of specific interventions provides information for directing focus.

Framework/Implementation on the DPH level – determines how we are going to help. Strategies, resources, templates, tool kits, and technology such as SharePoint – which provides a forum for calendars, discussion boards, and storage of information and deliverables – help direct the activities between Clinical and Community. Topic-specific Webinars such as those on Asthma, Budget Development, and Partnership Best Practices provide regular learning opportunities along with the weekly e-newsletter and individual TA coaching to assist with infrastructure and QI Plans.

An IHI model is used for rapid learning. Activities of the PWTF include:

Working with Grantees by asking them to share their challenges and encourage them to examine their work – what can they do to improve?

Drawing on expertise in the field for each intervention/condition – Provide access to Subject Matter Experts (SMEs).

Performing Coaching Site Visits and provide Individual Support via email and telephone to help grantees develop algorithms that streamline workflow and create a closed information loop.

Organizing and hosting Quarterly Learning Sessions where collaborative learning is encouraged and Communities of Practice develop. Smaller groups with specific knowledge meet to exchange experiences and share ideas to develop resource groups and tools to work collaboratively. Training takes place internally on Quality Improvement and Topics and the same framework can be used for external training of CHWs.

Summary evaluations provide us with feedback on Learning Sessions. Feedback from a recent Learning Session expresses the value of working together collaboratively during breakout sessions. Also, the review of a Condition Specific Algorithm Sample was appreciated. The work group lead walled through how patients are seen, assessed,

referred, and feedback is received and processed. The group leader encourages various approaches and brainstorms with the group about their processes. For example: One group arrived at the conclusion that they need a HUB for referral to manage two-way communication. The Falls Prevention group expressed that the algorithms help frame their process. Algorithms help them to think connectively about workflow and how information gets back to the Primary Care Clinician.

Questions: Susan Servais, Executive Director Massachusetts Health Council, Inc. (Consumer Health Organization) asked: Where does the algorithm lead when the referral hasn't completed the process or is a no show?

Response: Laura Coe replied that algorithms are new to many community-based agencies and our experience in the field shows that they are developing systems modeled, in part, after the sample algorithm.

There are examples in each of 9 Partnerships:

Pediatric Asthma – BPHC will utilize an electronic communications link for Boston Public Schools to allow exchange of information between the School Nurse and PCP.

Worcester is using both clinical and community-based CHWs for a new innovative approach.

Elder Falls Prevention – Quincy and Weymouth – Health Department Nurses are being funded to work preventing falls in the community.

Elder Falls Prevention – New Bedford is implementing a large system for Falls Risk Assessment that will likely serve as a model.

Hypertension – Berkshire Senior Services is embedded at the Community Health Center

Barnstable – Three Health Centers are collaborating to do referrals

Holyoke – is connecting Clinical Partners electronically

Metro West Partnership – Integrating their programming amongst 4 Boards of Health

<u>Challenges and Positives</u>

"Favorite days are in the field" PWTF is in our own capacity-building phase. We are hiring additional resources and developing a relationship of trust with the Partnerships.

Challenges:

Eagerness to implement – ahead of anticipating the level of need and setting down the foundation.

Balance: Evidence Innovation w Robust ROI Evidence Innovating for Cost Savings

e-Referral Demonstration – Laura Nasuti

Where we are – Lessons learned – how e-Referral Team partners with PWTF Team

6 States were awarded funding to test e-Referral pilot and program software system. They selected whom they would partner with. Pilot sites are Community Health Centers. A CHIA drive was used for medical records. CHIA has the capacity to extract information on whether or not e-Referral was used and acted upon and, if acted upon, provide the outcome information. This technology enables tracking services to health outcomes. The linkage of Clinical – Community – Clinical can help leverage programs statewide.

Pilot Community Health Centers are Brockton, Harbor Health, and Manet. They all chose their interventions.

Early lessons learned:

Overall workflow and developing business rules where there is not a formal process. Development of rules needed to determine how, when, and how many times a community based organization attempts contact and when do they direct back to the clinical organization. An example would be Meals On Wheels – When is the appropriate time for the feedback loop to close? How long does the referral remain open?

Promotion of making the referrals- different Partners have distinct needs.

Data sharing Agreements – Community-based organizations need to build capacity to deal with data sharing.

e-Referral (launched in June) – working with PWTF and Partnerships to educate about e-Referral. Workflow piece is critical in addition to the technology.

Gateway Demo: 3 Parts to e-Referral

1. The Referral: Clinical – has the ability to send directly from medical record. Gateway allows the community-based user to function like an email inbox. Displayed will be where the referral comes from, who is the main contact, and pertinent information from medical record is sent.
2. Feedback: Reports can be reviewed/created. A referral can be opened or closed and "activity status" can provide details on participation. Required documents can be attached and

3. Sent to Clinical organization and can be embedded into the electronic medical record.

e-referral - Susan Svencer – TA Generalist – is the liaison between PWTF and e-Referral

Material Development Checklists are used to track and update what is needed to go live with e-Referral.
FAQs and Glossaries of Terms clarify information involved in processes
A collaborative model allows examples to be drawn from what works and to be shared.

Comment: Lisa Renee Holderby-Fox – Board Member – Acknowledges the Team's effort and comments on the amount of work and the learning curve involved for Community Organizations and that it seems manageable as presented.

Comment: Carlene Pavlos: Acknowledges that the greatest challenge is talking about Workflow. The TA coaches are performing the critical work involved in preparation for onboarding e-Referral.

Comment: Lissette Blondet – Community TA/QI: Agrees that workflow is essential and that the discussion with grantees is multi-layered. 10% technology 90% common sense. The community organizations must have an understanding of how things relate.

Question: Susan Servais asks: Where does HPPA fall into this? Are patients asked to sign-off that their information is being shared with a community organization?

Response: Carlene Pavlos replied that she has been working with the Mass League and DPH's own legal team to address the need for consent and a Data Sharing Agreement is in development. DPH is comfortable with the partnerships sharing data with DPH and we are still working on that question.

Response: Laura Nasuti, OSE Deputy Director, mentioned that there is already double consent in the Clinical Social Work model. They always consent their patients. Also, there is a need to simplify – determine what info is needed and then restrict info. Determine what that means in terms of consent. This is a consideration also for data that partnerships share with DPH.

Question: Stephenie Lemon asks if the clinical partners are buying in to the e-referral model?

Response: Laura Nasuti replied that clinical providers do buy in. The level of interest of clinicians will vary by site. Some Community Centers have co-location with clinical sites. Provider buy-in and

provider trust could be issues. Provider trust issue is not evident because pilot sites were already on board.

Response: Pattie Daly provides an example from the field: Ask Doctors to recommend e-Referral programs to their colleagues. The YMCA is hosting educational sessions for Providers.

Dr. Thomas Land, Director Data Management Outcomes and Assessment/Evaluation – discusses the pattern of information that comes in – the systems work effectively – acceleration of the data will result in a pattern and we will look for that pattern.

Final Evaluation Plan –

RFP for Evaluation Groups – Evaluation Summits gave advice on how to evaluate the PWTF. What should the baseline information be? MDPH Net system is a looped system that is query-based. Harvard Vanguard and Atrius Health allow access to health information and will be useful for identifying prospective territories for PWTF. MDPH Net system compares data with other data sources (BPFSS) and accuracy is confirmed. Solid estimates for very small populations allow us to look at data and identify where MDPH Net is weak. Where do we need to add PWTF sites and supplement their funds?

Estimating Impact:

We can use existing data to estimate a baseline and measure the impact of the work that we've done. Evaluating the data – using the data linkage across Clinical and Community organizations will help determine whether a policy or service resulted in a change in that population's health and healthcare costs. Data linkage will allow comparison of cases, communities and comparison with areas outside of communities. Trend lines will illustrate changes – will be able to correlate rapid reduction in risk and cost reduction with policy change. Full cost estimates will be based on forecast.

We plan to involve Grantees in the process of developing the evaluation process. We will present to grantees the current framework and thinking of the evaluation framework and conduct a Request For Information for researchers to propose ideas on how PWTF should be evaluated and identify what team members are needed.

Next meeting:

December 11, 1:00 – 2:30

Meeting Closed.